PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND COMPLETE FORM ON REVERSE SIDE.

Cardholder's Information (The Cardholder is the insured member whose employer provides this benefit.)

1. Print Cardholder's name (last, first, middle initial)
2. Print Cardholder's date of birth
3. Circle the correct letter to indicate if Cardholder is male or female
4. Print Cardholder's ID number (found on prescription drug or Health Insurance card)
5. Print Cardholder's mailing address and telephone numbers. Check box if this is a new address.
6. Indicate Cardholder's employer, insurance carrier and group number (refer to drug card)

IMPORTANT: CLAIM FORM MUST BE SIGNED.
UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED

Patient Information (Complete a section for <u>each</u> family member who is submitting prescriptions.)

1. Print Patient's name
2. Identify relationship to cardholder, gender, date of birth, and number of prescriptions submitted for each patient
3. Print Pharmacy name and address and the prescribing Doctor and DEA number used by each patient.

Specific Claim Information

1. Answer each question by checking correct box. Use the space provided for special notes if necessary.

Prescription Information Each submission must include:
Prescription receipts/labels **<u>or</u>** a patient history printout from your pharmacy, **signed** by the dispensing pharmacist, which include all information listed below:

- Pharmacy name and address
- Date filled
- Drug name, strength and NDC number
- Rx Number
- Quantity
- Days Supply
- Price
- Patient's name

(Please note that Claims received missing any of the following information may be returned or payment may be denied.)

It is preferable to have receipts unattached or taped to a separate piece of paper. *Please* DO NOT staple or glue.

Reason for claim submission or special notes
This section can be used for special notes or comments.

Questions? Call Express Scripts Customer Service Department at 1-877-256-4677.

Please return this claim to: **Express Scripts, Inc.**
P.O. Box 390873
Bloomington, MN 55439-0873
ATTN: Claims Department

EXPRESS SCRIPTS
Charting the Future of Pharmacy

Public Employees Insurance Agency

PRESCRIPTION DRUG CLAIM FORM
West Virginia Public Employees Insurance Agency

DIV WVA

Cardholder's Name (last, first, MI)	Date Of Birth	Gender ☐ M ☐ F	Cardholder ID Number

☐ Check if new address (Please contact plan administrator to ensure correct address is on file)

Address Street_____

City/State_____ Zip Code_____ Daytime Telephone _____

Employer	Insurance Carrier	Group Number

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor.

Cardholder's Signature **Date**

Patient Information (please list information for each patient submitting claims)

1	**Patient's Name**	**Relationship to Cardholder?(circle)** **Self, Spouse, Child, Domestic Partner**	**Gender (circle)** **M ☐ F ☐**	**Date of Birth**	**How many prescriptions attached?**
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor) and DEA#:		

2	**Patient's Name**	**Relationship to Cardholder?(circle)** **Self, Spouse, Child, Domestic Partner**	**Gender (circle)** **M ☐ F ☐**	**Date of Birth**	**How many prescriptions attached?**
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor) and DEA#:		

3	**Patient's Name**	**Relationship to Cardholder?(circle)** **Self, Spouse, Child, Domestic Partner**	**Gender (circle)** **M ☐ F ☐**	**Date of Birth**	**How many prescriptions attached?**
Pharmacy Name and Address			Physician Name (name of prescribing Doctor) and DEA#: dsfdsfsdffsdfs		

Is claim for Diabetic Supply? ☐ yes ☑ no. If **Yes**, Patient's name dfdsfsdfsdfdsdsfs

Type of supply (lancets, syringe, etc.)_____ Quantity_____ Days Supply_____

Does the patient reside in an assisted living facility? ☐ yes ☐ no Is this claim for allergy serum? ☐ yes ☐ no

Does the patient have primary prescription drug coverage through another insurance carrier? ☐ yes ☐ no

Did the patient submit this claim to the other carrier? ☐ yes ☐ no *If yes, please attach an explanation of benefits from your primary carrier.*

Prescription Information

➔ **IMPORTANT** ← **All prescription claims must have prescriptions receipts/labels which include:**

• Pharmacy Name/Address • Date Filled • Drug Name, Strength and NDC • Rx Number • Quantity • Days Supply • Price •Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed

☒**Please tape receipts to separate piece of paper**

☒**Patient history print outs from the pharmacy are also acceptable but MUST be signed by the Pharmacist.**

☒**CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.**

REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:

ESI USE ONLY